DEPARTMENT OF FAMILY SERVICES
Office for Children
Child Care Assistance Program
12011 Government Center Pkwy. – 8th Floor
Fairfax, VA 22035
703-449-8484 or TDD 703-324-3923

EMPLOYMENT VERIFICATION

FAIRFAX COUNTY PROVIDES CHILD CARE ASSISTANCE TO LOW AND MODERATE-INCOME FAMILIES. TO BE ELIGIBLE FOR THIS PROGRAM, WORKING PARENTS MUST DOCUMENT HOURS OF WORK AND INCOME. PLEASE COMPLETE ALL INFORMATION REQUESTED BELOW.

Section I: Employee to complete

Employee's Name: _____ SSN: _____

Employee's Address: _____
(street) (city) (zip)

Employee's Home Telephone: _____

I authorize my employer to release information regarding my employment, salary and schedule.

_____ _____
Employee's Signature Date

Section II: Employer to complete

1. _____ works for me _____ hours per week at an hourly rate of _____.

2. This employee is paid: _____ weekly _____ biweekly (26 times/year)
_____ monthly _____ semi-monthly (24 times/year)

3. The employee **does** _____ / **does not** _____ receive pay stubs. If the employee does receive pay stubs according to company policy, the next one will be issued: _____.

4. Does this employee's work schedule vary from week to week? Yes _____ No _____

5. Complete employee's schedule:

Date	**Hours Scheduled**	
Mon	from:	to:
Tues	from:	to:
Wed	from:	to:
Thurs	from:	to:
Fri	from:	to:
Sat	from:	to:
Sun	from:	to:

Employee's Start Date: _____

Employer's Name: _____

Employer's Signature (please print): _____

Company or Organization: _____

Address: _____

_____

Employer's Telephone: _____

Date: _____